Please print or type **Date Issued:** _____

CONSUMER COMPLAINT FORM

Name of Nurse: _____
First Middle Last

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (___) _____ **Work Phone #:** (___) _____

Nurse's License #: _____ **Nurse's SS #:** _____

Nurse's Employer's Name: _____

Employer's Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer's Phone #: (___) _____ **Contact Person:** _____

Employer's E-Mail Address: _____

Your Name: _____
First Middle Last

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (___) _____ **Work Phone #:** (___) _____

Were you a patient of this nurse? ☐ Yes ☐ No

If so, during what period of time? _____

As a patient, will you consent to release to this Board, or its designated investigating body, copies of medical reports and records relating to you and to this occurrence from any hospital, related institution or physician? ☐ Yes ☐ No

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Please write a description in as much detail as possible, stating the exact nature of your complaint(s) against this nurse. (Use as many additional sheets as necessary, number them, and sign each one at the bottom.)

List the name, address, and telephone number of any witnesses to the occurrence(s), including any person who was present at the time of the occurrence(s).

Name	Address	Telephone #s

Have you made this complaint to any other person or organization? ☐ Yes ☐ No

If so, to whom? _____

I hereby declare and affirm under the penalties of perjury that the matters of facts set forth in the foregoing complaint are true and correct to the best of my knowledge, information, and belief.

_____ _____

Your Signature **Date**

The Board is not permitted to release any information about an investigation until a final order is issued. If you wish to be notified of the Board's decision in this case, please check below.

☐ Yes, I wish to be notified of the Board's decision.